ARTICLE 17

MEDICAID REFORM ACT

SECTION 1. Chapter 7.2 in Title 42 of the General Laws entitled " Office of Health and Human Services " is hereby amended by adding the following section:

42-7.2- 12 Medicaid Reform 2009. Legislative findings and intent-it is hereby found and declared as follows:

(a) The State of Rhode Island is facing annual deficits in excess of three hundred fifty million dollars ($350,000,000) for each of the next five years, 2009;2010;2011;2012;2013. During this time the Rhode Island Medicaid program is forecast to grow at a rate of seven (7) percent per year. Given the size of the Medicaid program and its impact on the state budget, this rate of growth is not financially sustainable:

(b) It is the intent of the Rhode Island general assembly that Medicaid shall be a sustainable, cost effective, person centered, and opportunity driven program utilizing competitive and value based purchasing to maximize the available service options; and

(c) It is the intent of the general assembly to fundamentally redesign the Medicaid Program in order to achieve a person-centered and opportunity driven program;

(d) It is the intent of the general assembly to:

1. create a Medical Assistance Program that is a results oriented system of coordinated care that focuses on independence and choice;

2. use competitive value based purchasing to maximize the available service options, promote accountability and transparency, and encourage and reward healthy outcomes and responsible choices; and

3. promote efficiencies between and among all health and human services agencies under the umbrella of the executive office of the health and human services, specifically between and among the department of human services, the state agency responsible for administration and implementation of Medicaid Reform 2009, the department children youth and families, the department of elderly affairs, the department of health, and the department of mental health retardation and hospitals.

Therefore, in order to promote personal responsibility, participant choice, dignity, competition and independence, the executive office of health and human services, the department of human services, the department of children, youth and families; the department of elderly affairs; the department of health; the department of mental health retardation, and hospitals, set forth the legislation provisions in Budget Article 17 in the 2008 legislative session for the purpose of reforming the state's Medicaid Program in furtherance of the following goals:

(a) Provide Medicaid assistance to eligible individuals;

(b) Provide community alternatives and least restrictive options for person centered choice and independence, as opposed to institutionalization;

(c) Provide for personal responsibility;

(d) Create a person-centered and opportunity driven program;

(e) Create a results oriented system of coordinated care that focuses on independence and choice;

(f) Use competitive value based purchasing to maximize the available service options and promote accountability and transparency; and

(g) Encourage and reward healthy outcomes and responsible choices.

RELATING TO THE EOHHS

SECTION 2. Chapter 7.2 in Title 42 of the General Laws entitled " Office of Health and Human Services " is hereby amended by adding the following section:

42-7.2-12.1 Reporting on Medicaid Reform 2009. The executive office of health and human services and/or the department of human services shall submit a report to general assembly annually commencing on a date no later than July 1, 2009. The report shall describe the progress and status regarding the administration and implementation of Medicaid Reform 2009 .

SECTION 3. Sections 14-1-11, 14-1-21, 14-1-27, 14-1-32, and 14-1-36 of the General Laws in Chapter 14-1 entitled "Proceedings in Family Court" are hereby amended to read as follows:

14-1-11 Authorizing and filing petition.[Contingent effective date; see note.]. – (a) The filing of the petition constitutes assumption of jurisdiction over the child. Filing shall take place upon authorization by the intake department upon completion of its procedures pursuant to Rule 3 of the Rules of Juvenile Proceedings, upon authorization by a justice of the family court pursuant to Rule 4 of the Rules of Juvenile Proceedings, or immediately upon appearance of the child before the court following emergency detention, unless the court otherwise orders.

(b) In the event that a petition is filed, any appropriate person having knowledge, information, or belief of the material facts that appear to warrant a petition may be a petitioner under this chapter and is not required to give recognizance or surety for costs. The petition shall be directed to the family court of the state of Rhode Island, setting forth that in the opinion of the petitioner the child is a delinquent, wayward, dependent, or neglected child, or otherwise comes within the provisions of this chapter, and requires the care and protection of the state, and all petitions, with the exception of those requesting the arrest and/or detention of any person, shall be sworn to before a licensed notary public. Those exceptions, as stated above, shall be sworn to by either a justice or clerk of the family court.

(c) No child shall be ordered detained at the training school, unless there is pending against the child a petition setting forth facts which would constitute a felony or misdemeanor if committed by an adult or which alleges a violation of a valid court order, or unless the child is adjudged in contempt of court. In the event a child is ordered to be detained at the training school, the family court shall conduct a probable cause hearing within seventy-two (72) hours of the child's detention (exclusive of weekends and/or holidays). At the conclusion of the probable cause hearing, the court shall order the release of the child from the training school unless the court finds that the child:

(1) Poses a substantial risk of harm to self; or

(2) Poses a substantial risk of harm to others; or

(3) Has demonstrated that he or she may leave the jurisdiction of the court.

~~Any child detained is entitled to a probable cause hearing within ten (10) days.~~ Nothing in this section prohibits the temporary commitment by the family court to the department of children, youth, and families for placement of a child in a specific facility or program other than the training school for youth.

(d) The department of children, youth and families, in consultation with law enforcement agencies, the attorney general, the office of the public defender and the family court, shall develop and implement a detention risk assessment instrument by no later than July 1, 2009. Upon implementation of said risk assessment instrument and except as authorized by the family court, no child who is taken into custody for an act

that would constitute a felony or misdemeanor if committed by an adult or which alleges a violation of a valid court order or unless the child is adjudged in contempt of court, shall be placed in detention at the training school unless a detention risk assessment instrument is completed by an entity or entities designated by the department of children, youth and families and the office of the attorney general. No child shall be placed in detention at the training school unless a determination is made by the family court that the child:

(1) poses a substantial risk of harm to self; or

(2) poses a substantial risk of harm to others; or

(3) has demonstrated that he or she may leave the jurisdiction of the court.

~~(d)~~ (e) No petition alleging that a child is wayward by virtue of disobedient behavior may be filed except upon proof offered in the petition that the child has been subjected to a needs assessment conducted at a facility approved by the director of the department of children, youth, and families, and that a treatment plan resulting from such an assessment has been unsuccessful.

~~(e)~~ (f) The department of children, youth, and families is authorized and directed to promulgate rules and regulations that it deems necessary to implement the provisions and purposes of this section.

§ 14-1-21 Release or detention of child under custody of court. – In the case of any child whose custody has been assumed by the court, the child may, pending the final disposition of the case, be released in the custody of a parent, guardian, or other custodian, or of a probation counselor or other person appointed by the court, to be brought before the court at the designated time. When not released as provided in this section, the child, pending the hearing of the case, shall be detained at the training school subject to § 14-1-11 and § 14-1-27. ~~in any place of detention that shall be designated by the court, subject to further order of the court.~~

§ 14-1-27 Temporary detention in public or private institutions. – (a) Subject to § 14-1-11, ~~P~~provision may be made by the family court for the temporary detention

of children ~~ordered to be detained~~ at the training school for youth or in the custody of the director of the department of children, youth and families. The court may authorize the temporary placement of children ~~arrange for the boarding of children temporarily~~ in private homes licensed and approved by the department of children, youth, and families and subject to the supervision of the court, or may arrange with any incorporated institution or agency licensed for child care, to receive for temporary care children ordered detained by the court. If a child is in detention, the family court shall commence the adjudicatory hearing within thirty (30) calendar days from whichever of the following events occurs latest: the date the petition is served on the child; or the date the child is placed in detention.

In all such cases, the family court shall conclude the adjudicatory hearing within fifteen 15 calendar days of the commencement of the hearing. ~~The detention shall not exceed thirty (30) days. The court, however, may extend this time for an additional period of not more than thirty (30) days if it considers it is for the best interest of the child.~~

(b) In any case wherein the attorney general files an application to waive and/or certify a youth, the juvenile may be detained at the training school for a period not to exceed ninety (90) days. In such cases, the department shall present to the family court a waiver report within forty-five (45) calendar days. At the expiration of ninety (90) days, the attorney general's petition for waiver and/or certification shall be decided and the wayward/delinquent petition shall be adjudicated.

~~(b)~~(c)When DCYF makes application to the court to take a child into temporary custody due to allegations of abuse and/or neglect or dependency, DCYF shall have the duty to investigate the possibility of placing the child or children with a fit and willing relative not residing with the parents. DCYF shall conduct an assessment into the appropriateness of placement of the child or children with the relative within thirty (30) days of the child's placement in the temporary custody of DCYF. If the department determines that the relative is a fit and proper person to have placement of the child, the child shall be placed with that relative, unless the particular needs of the child make the placement contrary to the child's best interests. All placements with relatives shall be subject to criminal records

checks in accordance with § 14-1-34, foster care regulations promulgated by DCYF, and interstate compact approval, if necessary.

~~(c)~~ (d) If DCYF proposes to place the child with a relative outside the state of Rhode Island, DCYF shall notify the parent who shall have an opportunity to file an objection to the placement with the family court within ten (10) days of receipt of the notice. A hearing shall be held before the child is placed outside the state of Rhode Island.

~~(d)~~ (e) If the request of a relative for placement of a child or children is denied by DCYF, that relative shall have the right to petition the court for review. The court shall within five (5) days of the request conduct a hearing as to the suitability of temporary placement with the relative and shall make any orders incident to placement that it deems meet and just.

~~(e)~~ (f) Whenever the court determines that permanent placement or adoption is in the best interest of a child, a fit and willing relative who has been awarded placement of the child shall be given priority over a non-relative, provided that the placement or adoption is in the best interest of the child.

SECTION 4. Section 14-1-36.1 of the General Laws in Chapter 14-1 entitled "Proceedings in Family Court" is hereby amended to read as follows:

14-1-36.1 Release from training school. – (a) No child sentenced to the training school for youth, after being found delinquent or wayward, shall be released prior to the end of his or her sentence unless authorized by a justice of the family court, after a hearing with due notice to the parties to the petition upon which the child was sentenced. At any such hearing, the family court shall authorize the release of the child to his or her home and/or to the care and custody of the department of children, youth and families unless the court finds that the child:

(1) Poses a substantial risk of harm to self; or

(2) Poses a substantial risk of harm to others; or

(3) Has demonstrated that he or she may leave the jurisdiction of the court.

(b) Provided that any child who has been certified and adjudicated pursuant to § 14-1-7.2 and § 14-1-7.3, may not be released prior to the end of his or her sentence except as authorized under § 14-1-42 of this chapter.

~~(b)~~ (c) A child so sentenced may be allowed as part of a rehabilitation program to be placed temporarily in a community program outside of the training school only when authorized by the family court.

SECTION 5. Chapter 14-1 of the General Laws in Title 14 entitled "Delinquent and Dependent Children" is hereby amended to add the following section:

§ 14-1-36.2 Assignment of custody to the director of the department of children, youth and families – In the event the court assigns custody of a child to the director of the department of children, youth and families pursuant to § 14-1-11, § 14-1-11.1, §14-1-27, §14-1-32, §14-1-34, §14-1-36, §14-1-36.1, §14-1-42, §40-11-7.1, and/or § 40-11-12, the court shall authorize the provision of suitable treatment, rehabilitation and care for each child in the least restrictive and community based setting.

SECTION 6. Section 40-6-9.1 of General Laws in Chapter 40-6 entitled "Public Assistance Act." is hereby amended to read as follows:

40-6-9.1 Data matching – Health care coverages. – (a) For purposes of this section, the term "medical assistance program" shall mean medical assistance provided in whole or in part by the department of human services pursuant to chapters 5.1, 8, 8.4 of title 40, 12.3 of title 42 and/or title XIX or XXI of the federal Social Security Act, as amended, 42 U.S.C. § 1396 et seq. and 42 U.S.C. § 1397aa et seq., respectively. Any references to the department shall be to the department of human services.

(b) In furtherance of the assignment of rights to medical support to the department of human services under § 40-6-9(b), (c), (d), and (e) and in order to determine the availability of other sources of health care insurance or coverage for beneficiaries of the medical assistance program, and to determine potential third party liability for medical assistance paid out by the department, all health insurers, health maintenance organizations, including managed care organizations, and third party administrators, self insured plans, pharmacy benefit managers (PBM), and other parties that are by statute,

contract, or agreement, legally responsible for payment of a claim for a health care item of service doing business in the state of Rhode Island shall permit and participate in data matching with the department of human services, as provided in this section, to assist the Department to identify medical assistance program applicants, beneficiaries and/or persons responsible for providing medical support for such applicants and beneficiaries who may also have health care insurance or coverage in addition to that provided or to be provided by the medical assistance program and to determine any third party liability in accordance with this section.

The department shall take all reasonable measures to determine the legal liability of all third parties (including health insurers, self-insured plans, group health plans (as defined in § 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. § 1167(1)]), service benefit plans, health maintenance organizations, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service), to pay for care and services on behalf of a medical assistance recipient, including collecting sufficient information to enable the department to pursue claims against such third parties.

In any case where such a legal liability is found to exist and medical assistance has been made available on behalf of the individual (beneficiary), the department shall seek reimbursement for such assistance to the extent of such legal liability and in accordance with the assignment described in § 40-6-9.

To the extent that payment has been made by the department for medical assistance to a beneficiary in any case where a third party has a legal liability to make payment for such assistance, and to the extent that payment has been made by the department for medical assistance for health care items or services furnished to an individual, the department (state) is considered to have acquired the rights of such individual to payment by any other party for such health care items or services in accordance with § 40-6-9.

Any health insurer (including a group health plan, as defined in § 607(1) of the employee retirement income security act of 1974 [29 U.S.C. § 1167(1)], a self-insured plan, a service benefit plan, a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a

claim for a health care item or service), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, is prohibited from taking into account that the individual is eligible for or is provided medical assistance under a plan under 42 U.S.C. § 1396 et seq. for such state, or any other state.

(c) All health insurers, including, but not limited to, health maintenance organizations, third party administrators, nonprofit medical service corporations,nonprofit hospital service corporations, subject to the provisions of chapters 18, 19, 20 and 41 of title 27, as well as, self-insured plans, group health plans (as defined in § 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. § 1167(1)]), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) doing business in this state shall:

(i) Provide timely (accurate within fourteen (14) calendar days of the request) member information to the department to enable the medical assistance program to identify medical assistance program recipients, applicants and/or persons responsible for providing medical support for those recipients and applicants who are or could be enrollees or beneficiaries under any individual or group health insurance contract, plan or policy available or in force and effect in the state;

(ii) With respect to individuals who are eligible for, or are provided, medical assistance by the department, upon the request of the department, provide timely (accurate within fourteen (14) calendar days of the request) member information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan);

(iii) Accept the state's right of recovery and the assignment to the state of any right of an individual or other entity to payment from the party for an item or service for which payment has been made by the department;

(iv) Respond to any inquiry by the department regarding a claim for payment for any health care item or service that is submitted not later than three (3) years after the date of the provision of such health care item or service; and

(v) Agree not to deny a claim submitted by the state based solely on procedural reasons such as on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if–

(I) The claim is submitted by the state within the three (3) year period beginning on the date on which the item or service was furnished; and

(II) Any action by the state to enforce its rights with respect to such claim is commenced within six (6) years of the state's submission of such claim.

(d) This information shall be made available by these insurers and health maintenance organizations and used by the department of human services only for the purposes of and to the extent necessary for identifying these persons determining the scope and terms of coverage, and ascertaining third party liability. The department of human services shall provide information to the health insurers, including health insurers, self-insured plans, group health plans (as defined in § 607(1) of the employee retirement income security act of 1974 [29 U.S.C. § 1167(1)]), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) only for the purposes described herein.

(e) No health insurer, health maintenance organization, or third party administrator which provides or makes arrangements to provide information pursuant to this section shall be liable in any civil or criminal action or proceeding brought by beneficiaries or members on account of this action for the purposes of violating confidentiality obligations under the law.

(f) The department shall submit any appropriate and necessary state plan provisions.

RELATIING TO DHS

SECTION 7. Section 40-8-2 of the General Laws in Chapter 40-8 entitled "Medical Assistance" is hereby amended to read as follows:

40-8-2 Definitions. – As used in this chapter, unless the context shall otherwise require:

(1) "Dental service" means and includes emergency care, X-rays for diagnoses, extractions, palliative treatment, and the refitting and relining of existing dentures and prosthesis.

(2) "Department" means the department of human services.

(3) "Director" means the director of human services.

(4) "Drug" means and includes only such drugs and biologicals prescribed by a licensed dentist or physician as are either included in the United States pharmacopoeia, national formulary, or are new and nonofficial drugs and remedies.

(5) "Inpatient" means a person admitted to and under treatment or care of a physician or surgeon in a hospital or nursing facility which meets standards of and complies with rules and regulations promulgated by the director.

(6) "Inpatient hospital services" means the following items and services furnished to an inpatient in a hospital other than a hospital, institution or facility for tuberculosis or mental diseases:

(i) Bed and board;

(ii) Such nursing services and other related services as are customarily furnished by the hospital for the care and treatment of inpatients and such drugs, biologicals, supplies, appliances, and equipment for use in the hospital, as are customarily furnished by the hospital for the care and treatment of patients;

(iii) Such other diagnostic or therapeutic items or services, including, but not limited to, pathology, radiology, and anesthesiology furnished by the hospital or by others under arrangements made by the hospital, as are customarily furnished to inpatients either by the hospital or by others under such arrangements, and services as are customarily provided to inpatients in the hospital by an intern or resident-in-training under a teaching program having the approval of the Council on Medical Education and Hospitals of the American Medical Association or of any other recognized medical society approved by the director.

(B) The term "inpatient hospital services" shall be taken to include medical and surgical services provided by the inpatient's physician, but shall not include the services of a private duty nurse or services in a hospital, institution, or facility maintained primarily for the treatment and care of patients with tuberculosis or mental diseases. Provided, further, it shall be taken to include only the following organ transplant operations: kidney, liver, cornea, pancreas, bone marrow, lung, heart, and heart/lung, and such other organ transplant operations as may be designated by the director after consultation with medical advisory staff or medical consultants; and provided that any such transplant operation is determined by the director or his or her designee to be medically necessary. Prior written approval of the director or his or her designee shall be required for all covered organ transplant operations.

(C) In determining medical necessity for organ transplant procedures, the state plan shall adopt a case-by-case approach and shall focus on the medical indications and contra-indications in each instance, the progressive nature of the disease, the existence of any alternative therapies, the life threatening nature of the disease, the general state of health of the patient apart from the particular organ disease, and any other relevant facts and circumstances related to the applicant and the particular transplant procedure.

(7) "Managed care" is defined as systems that: integrate an efficient financing mechanism with quality service delivery; provides a "medical home" to assure appropriate care and deter unnecessary and inappropriate care; and places emphasis on preventive and primary care. For purposes of Medical Assistance, managed care is also

defined to include a primary care case management model in which ancillary services are provided under the direction of a physician in a practice that meets standards established by the department of human services.

~~(7)~~ (8) "Nursing services" means the following items and services furnished to an inpatient in a nursing facility:

(i) Bed and board;

(ii) Such nursing care and other related services as are customarily furnished to inpatients admitted to the nursing facility, and such drugs, biologicals, supplies, appliances, and equipment for use in the facility, as are customarily furnished in the facility for the care and treatment of patients;

(iii) Such other diagnostic or therapeutic items or services, legally furnished by the facility or by others under arrangements made by the facility, as are customarily furnished to inpatients either by the facility or by others under such arrangement;

(iv) Medical services provided in the facility by the inpatient's physician, or by an intern or resident-in-training of a hospital with which the facility is affiliated or which is under the same control, under a teaching program of the hospital approved as provided in subsection (6) of this section; and

(v) A personal needs allowance of fifty dollars ($50.00) per month.

~~(8)~~ (9) "Relative with whom such dependent child is living" means and includes the father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece of any dependent child who maintains a home for the dependent child.

~~(9)~~ (10) "Visiting nurse service" means part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse other than in a hospital or nursing home.

RELATING TO THE DHS

SECTION 8. Section 40-8-4 of the General Laws in Chapter 40-8 entitled "Medical Assistance " is hereby amended to read as follows:

§ 40-8-4 Direct vendor payment plan. – (a) The department shall furnish medical care benefits to eligible beneficiaries through a direct vendor payment plan. The plan shall include, but need not be limited to, any or all of the following benefits, which benefits shall be contracted for by the director:

(1) Inpatient hospital services, other than services in a hospital, institution, or facility for tuberculosis or mental diseases;

(2) Nursing services for such period of time as the director shall authorize;

(3) Visiting nurse service;

(4) Drugs for consumption either by inpatients or by other persons for whom they are prescribed by a licensed physician;

(5) Dental services; and

(6) Hospice care u~~p to a maximum of two hundred and ten (210) days as a lifetime benefit.~~

(b) For purposes of this chapter, the payment of federal Medicare premiums or other health insurance premiums by the department on behalf of eligible beneficiaries in accordance with the provisions of Title XIX of the federal Social Security Act, 42 U.S.C. § 1396 et seq., shall be deemed to be a direct vendor payment.

(c) With respect to medical care benefits furnished to eligible individuals under this chapter or Title XIX of the federal Social Security Act, the department is authorized and directed to impose:

(i) Nominal co-payments or similar charges upon eligible individuals for non-emergency services provided in a hospital emergency room; and

(ii) Co-payments for prescription drugs in the amount of one dollar ($1.00) for generic drug prescriptions and three dollars ($3.00) for brand name drug prescriptions in accordance with the provisions of 42 U.S.C. § 1396, et seq.

(d) The department of human services and/or the executive office of health and human services is authorized and directed to apply for and obtain any necessary waiver (s) and/or state plan amendments from the secretary of the United States Department of Health and Human Services, including, but not limited to, a waiver of the appropriate sections of law for the purpose of administering and implementing the goals of the Medicaid Reform 2009 as described in 42- 7.2-12 of the General Laws, specifically for the purpose of using competitive value based purchasing to maximize the available service options and to promote accountability and transparency in the delivery of services for all medical assistance recipients.

(e) Any approved medical assistance provider who declines to participate in contracting for benefits in any one of the department's medical assistance programs may be denied participation in all state operated medical assistance programs at the discretion of the department.

(f) The department is authorized and directed to promulgate rules and regulations to impose such co-payments or charges and to provide that, with respect to subdivision (ii) above, those regulations shall be effective upon filing.

RELATING TO THE DHS

SECTION 9. Section 40-8-17 of the General Laws in Chapter 40-8 entitled "Medical Assistance" is hereby amended as follows:

§ 40-8-17 Waiver request – Formulation. – (a) The department of human services and/or the executive office of health and human services ~~and the department of elderly affairs shall cooperate and collaborate in the formulation of a 2176 waiver request to the health care financing administration.~~ is authorized and directed to apply for and obtain any necessary waiver (s) and/or state plan amendments from the secretary of the United States Department of Health and Human Services, including, but not limited to, a waiver of the appropriate sections of law for the purpose of administering and implementing the goals of the Medicaid Reform 2009 as described in 42- 7.2-12 of the General Laws. The purpose of the waiver is to create a Medical Assistance Program that is a result oriented system of coordinated care that focuses on independence, personal responsibility and choice for all medical assistance recipients taking into account the best interests of all populations served by all five human service agencies. ~~The waiver shall be designed to bring people who have been admitted to nursing homes back into the community. The department of human services and the department of elderly affairs shall formulate the waiver application forthwith. In no event shall the waiver request be submitted later than August 1, 1987.~~

~~(b) The department of elderly affairs shall, forthwith, formulate and effectuate a coordinated outreach and education program to create an awareness of the alternatives to nursing home placement. The outreach and education program shall be directed to both health care providers and potential clients.~~

(b)The executive office of health and human services, the department of human services, the department of children youth and families, the department of children youth and families, the department of elderly affairs, the department of health, and the department of mental health, retardation and hospitals are authorized and directed to adopt regulations to ensure the establishment and implementation of this section in accordance with the intent and purpose outlined in this section, the requirements of Title XIX , 42 U.S.C. § 1396 et seq., and Title XXI, 42 USC § 1397 et seq., and any approved federal waivers and/or state plan amendments.

RELATING TO THE DHS

SECTION 10. Section 40-8.4-4 of the General Laws in Chapter 40- 8.4 entitled " Health Care for Families " is hereby amended as follows:

40-8.4-4 Eligibility. – (a) Medical assistance for families. There is hereby established a category of medical assistance eligibility pursuant to § 1931 of Title XIX of the Social Security Act, 42 U.S.C. § 1396u-1, for families whose income and resources are no greater than the standards in effect in the aid to families with dependent children program on July 16, 1996 or such increased standards as the department may determine. The department of human services is directed to amend the medical assistance Title XIX state plan and to submit to the U.S. Department of Health and Human Services an amendment to the RIte Care waiver project to provide for medical assistance coverage to families under this chapter in the same amount, scope and duration as coverage provided to comparable groups under the waiver. The department is further authorized and directed to submit such amendments and/or requests for waivers to the Title XXI state plan as may be necessary to maximize federal contribution for provision of medical assistance coverage under this chapter. However, implementation of expanded coverage under this chapter shall not be delayed pending federal review of any Title XXI amendment or waiver.

(b) Income. The director of the department of human services is authorized and directed to amend the medical assistance Title XIX state plan or RIte Care waiver to provide medical assistance coverage through expanded income disregards or other methodology for parents or relative caretakers whose income levels are equal to or up to one hundred thirty three (133%) ~~below one hundred eighty-five percent~~ of the federal poverty level In addition, the department of human services is authorized and directed to apply for and obtain appropriate waivers and/or state plan amendments from the Secretary of the U.S. Department of Health and Human Services, for, including but not limited to, a redesigned benefit package for parents or relative caretakers not receiving cash

assistance under the Rhode Island Temporary Assistance to Needy Families (TANF program) and above one hundred (100%) percent of the federal poverty level.

~~(c) Resources. Except as provided herein, no family or child shall be eligible for medical assistance coverage provided under this section if the combined value of the child's or the family's liquid resources exceed ten thousand dollars ($10,000); provided, however, that this subsection shall not apply to:~~

~~(1) children with disabilities who are otherwise eligible for medical assistance coverage as categorically needy under Section 134(a) of the Tax Equity and Fiscal Responsibility Act of 1982 [federal P.L. 97-248], commonly known as Katie Beckett eligible, upon meeting the requirements established in Section 1902(e)(3) of the federal Social Security Act; and~~

~~(2) pregnant women.~~

~~Liquid Resources are defined as any interest(s) in property in the form of cash or other financial instruments or accounts which are readily convertible to cash or cash equivalents. These include, but are not limited to: cash, bank, credit union or other financial institution savings, checking and money market accounts, certificates of deposit or other time deposits, stocks, bonds, mutual funds, and other similar financial instruments or accounts. These do not include educational savings accounts, plans, or programs; retirement accounts, plans, or programs; or accounts held jointly with another adult, not including a spouse, living outside the same household but only to the extent the applicant/recipient family documents the funds are from sources owned by the other adult living outside the household, plus the proportionate share of any interest, dividend or capital gains thereon. The department is authorized to promulgate rules and regulations to determine the ownership and source of the funds in the joint account.~~

~~(d)~~(c) Waiver. (1) The department of human services is authorized and directed to apply for and obtain appropriate waivers and/or state plan amendments from the Secretary of the U.S. Department of Health and Human Services, including, but not limited to, a waiver of the appropriate provisions of Title XIX, to require that individuals with incomes equal to or greater than one hundred ~~fifty~~ thirty-three percent ~~(150%)~~ (133%) of the federal poverty level pay a share of the costs of their medical assistance coverage,

provided through enrollment in either the RIte Care Program or in accordance with the premium assistance program provisions of section § 40-8.4-12. in a manner and at an amount consistent with comparable cost-sharing provisions under § 40-8.4-12~~, provided that such cost sharing shall not exceed five percent (5%) of annual income; and provided, further, that c~~ Cost-sharing shall not be required for pregnant women or children under age one. All children and families receiving medical assistance through RIte Care Program or in accordance with the premium assistance program provisions of section 40-8.4-12, shall also be subject to co-payments for certain services as specified and as approved in the waiver and/or the applicable state plan amendment and in accordance with rules and regulations promulgated by the department.

(2) The department of human services and/or the executive office of health and human services is further directed to apply for and obtain appropriate waivers and/or state plan amendments from the Secretary of the U.S. Department of Health and Human Services for the purpose of requiring that families of children with disabilities who are otherwise eligible for medical assistance coverage as categorically needy under Section 134(a) of the Tax Equity and Fiscal Responsibility Act of 1982 [federal P.L. 97-248], commonly known as Katie Beckett eligible, upon meeting the requirements established in Section 1902(e)(3) of the federal Social Security Act, will be required to take financial responsibility for a share of the cost of the medical assistance coverage based on the family's ability to pay. The department is authorized to require that eligible children/ families contribute to the cost of the care by premium sharing, cost sharing, the establishment of consumer directed accounts or any other reasonable means in accordance with approved provisions of appropriate waivers and/or state plan amendments from the secretary of the United States Department of Health and Human Services and in accordance with rules and regulations promulgated by the department of human services.

(d) Consumer Directed Health Care. The department of human services is authorized and directed to apply for and obtain appropriate waivers from the Secretary of the U.S. Department of Health and Human Services, including, but not limited to, a waiver of the appropriate provisions of Title XIX, to create consumer directed health care accounts to

increase and encourage personal responsibility, wellness and healthy decision-making. The waiver may also permit the State to provide gift cards or other tangible incentives for beneficiaries who meet designated wellness initiatives.

SECTION 11. Section 10 of this Article shall take effect upon passage. Any rules or regulations necessary or advisable to implement the provisions of Section 10 of this Article shall be effective immediately as an emergency rule upon the department's filing thereof with the secretary of state as it is hereby found that the current fiscal crisis in this state has caused an imminent peril to public health, safety and welfare, and the department is hereby exempted from the requirements of sections 42-35-3(b) and 42-35-4(b)(2) relating to agency findings of imminent peril to public health, safety and welfare and the filing of statements of the agency's reasons thereof.

RELATING TO DHS

SECTION 12. Section 40-8.4-12 of the General Laws in Chapter 40-8.4 entitled "Health Care for Families" is hereby amended as follows:

§ 40-8.4-12 RIte Share Health Insurance Premium Assistance Program. – ~~(1)~~ (a) The department of human services is authorized and directed to amend the medical assistance Title XIX state plan to implement the provisions of § 1906 of Title XIX of the Social Security Act, 42 U.S.C. § 1396e, and establish the Rhode Island health insurance premium assistance program for RIte Care eligible parents with incomes up to one hundred ~~eighty-five percent (185%)~~ thirty three (133%) of the federal poverty level who have access to employer-based health insurance. The state plan amendment shall require eligible individuals with access to employer-based health insurance to enroll themselves and/or their family in the employer-based health insurance plan as a condition of participation in the RIte Share program under this chapter and as a condition of retaining eligibility for medical assistance under chapters 5.1 and 8.4 of this title and/or chapter 12.3 of title 42 and/or premium assistance under this chapter, provided that doing so meets the criteria established in § 1906 of Title XIX for obtaining federal matching funds and the department has determined that the individual's and/or the family's enrollment in

the employer-based health insurance plan is cost-effective and the department has determined that the employer-based health insurance plan meets the criteria set forth in subsection (d). The department shall provide premium assistance by paying all or a portion of the employee's cost for covering the eligible individual or his or her family under the employer-based health insurance plan, subject to the cost sharing provisions in subsection (b), and provided that the premium assistance is cost-effective in accordance with Title XIX, 42 U.S.C. § 1396 et seq.

~~(2) Resources. Except as provided herein, no family, individual, or child shall be eligible for medical assistance coverage provided under this section if the combined value of the child's or family's liquid resources exceeds ten thousand dollars ($10,000); provided, however, that this subsection shall not apply to:~~

~~(i) children with disabilities who are otherwise eligible for medical assistance coverage as categorically needy under Section 134(a) of the Tax Equity and Fiscal Responsibility Act of 1982 [federal P.L. 97-248], commonly known as Katie Beckett eligible, upon meeting the requirements established in § 1902(e)(3) of the federal Social Security Act, and~~

~~(ii) pregnant women.~~

(b) Individuals who can afford it shall share in the cost. The department of human services is authorized and directed to apply for and obtain any necessary waivers and/or state plan amendments from the secretary of the United States Department of Health and Human Services, including, but not limited to, a waiver of the appropriate sections of Title XIX, 42 U.S.C. § 1396 et seq., to require that individuals eligible for RIte Care under this chapter or chapter 12.3 of title 42 with incomes equal to or greater than one hundred thirty three (133%) ~~fifty~~ percent ~~(150%)~~ of the federal poverty level pay a share of the costs of health insurance based on the individual's ability to pay. The department of human services shall implement the cost-sharing obligation by regulation, and shall consider co-payments, premium shares , or other reasonable means to do so in accordance with approved provisions of appropriate waivers and/or state plan amendments from the secretary of the United States Department of Health and Human Services. ~~provided that the cost sharing shall not exceed five percent (5%) of the individual's annual income~~ All children and families receiving medical assistance

through the RIte Care Program or in accordance with the premium assistance program provisions of this section shall also be subject to co-payments for certain services as specified and as approved in the waiver and/or the applicable state plan amendment, and in accordance with rules and regulations promulgated by the department..

(c) Current RIte Care enrollees with access to employer-based health insurance or health benefits. The department of human services shall require any individual who receives RIte Care or whose family receives RIte Care on the effective date of the applicable regulations adopted in accordance with subsection ~~(f)~~ (h) to enroll in an employer-based health insurance or health benefit plan at the individual's eligibility redetermination date or at an earlier date determined by the department, provided that doing so meets the criteria established in the applicable sections of Title XIX, 42 U.S.C. § 1396 et seq., for obtaining federal matching funds and the department has determined that the individual's and/or the family's enrollment in the employer-based health insurance plan is cost-effective and has determined that the health insurance plan meets the criteria in subsection (d). The insurer and the employee shall accept the enrollment of the individual and/or the family in the employer-based health insurance plan without regard to any enrollment season restrictions.

(d) Approval of health insurance or health benefit plans for premium assistance. The department of human services shall adopt regulations providing for the approval of employer-based health insurance or health benefit plans for premium assistance and shall approve employer-based health insurance plans based on these regulations. In order for an employer-based health insurance or health benefit plan to gain approval, the department must determine that the benefits offered by the employer-based health insurance plan are substantially similar in amount, scope, and duration to the benefits provided to RIte Care eligible persons by the RIte Care program, when the plan is evaluated in conjunction with available supplemental benefits provided by the department. The department shall obtain and make available to persons otherwise eligible for RIte Care as supplemental benefits those benefits not reasonably available under employer-based health insurance plans which are required for RIte Care eligible persons by state law or federal law or regulation. The employer shall make available at the department's request in a timely fashion , documents describing the health insurance or

health benefits offered by the employer including, but not limited to, a Certificate of Coverage or a Summary of benefits and employee obligations in order to comply with the provisions of this section.

(e) Employers who are approved Medicaid Providers. Employers who are also approved Medicaid providers shall make available in a timely manner to the department at the department's request, documents describing the health insurance or health benefits offered by the employer, including but not limited to a Certificate of Coverage or a Summary of Benefits and employee obligations. The Employer shall accept the enrollment of the individual and/or the family in the employer based health insurance plan without regard to any seasonal enrollment restrictions, including open enrollment restrictions, without regard to the impact on the member's wages. This is known as "pay in lieu of benefits."

(f) Vendors doing business in the state of Rhode Island. All vendors doing business with the state of Rhode Island in accordance with Title 37 of the General Laws and who are also employers of Rhode Island medical assistance recipients shall make available in a timely manner to the department at the department's request, documents describing the health insurance or health benefits offered by the vendor to the employee, including, but not limited to a Certificate of Coverage or a Summary of Benefits and employee obligations for the purposes of and only to the extent necessary to carry out the provisions of this section of the General Laws The employer shall accept the enrollment of the individual and/or the family in the employer based health insurance plan without regard to any seasonal enrollment restrictions, including open enrollment restrictions, without regard to the impact on the member's wages. This is known as "pay in lieu of benefits."

~~(e)~~ (g) Maximization of federal contribution. The department of human services is authorized and directed to apply for and obtain federal approvals, including state plan amendments, and waivers necessary to maximize the federal contribution for provision of medical assistance coverage under this section.

~~(f)~~(h) Implementation by regulation. The department of human services is authorized and directed to adopt regulations to ensure the establishment and implementation of the premium assistance program in accordance with the intent and purpose of this section, the

requirements of Title XIX and any approved federal waivers and /or state plan amendments.

SECTION 13. Section 12 of this Article shall take effect upon passage. Any rules or regulations necessary or advisable to implement the provisions of Section 12 of this Article shall be effective immediately as an emergency rule upon the department's filing thereof with the secretary of state as it is hereby found that the current fiscal crisis in this state has caused an imminent peril to public health, safety and welfare, and the department is hereby exempted from the requirements of sections 42-35-3(b) and 42-35-4(b)(2) relating to agency findings of imminent peril to public health, safety and welfare and the filing of statements of the agency's reasons thereof.

RELATING TO DHS

SECTION 14. Section 40-8.5- 1 of the General Laws in Chapter 40-8.5 entitled "Health Care for Elderly and Disabled Residents Act " is hereby amended as follows:

§ 40-8.5-1 Categorically needy medical assistance coverage. – (a) The department of human services is hereby authorized and directed to amend its Title XIX state plan to provide for categorically needy medical assistance coverage as permitted pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., as amended, to individuals who are sixty-five (65) years or older or are disabled, as determined under § 1614(a)(3) of the Social Security Act, 42 U.S.C. § 1382c(a)(3), as amended, whose income does not exceed one hundred percent (100%) of the federal poverty level (as revised annually) applicable to the individual's family size, and whose resources do not exceed four thousand dollars ($4,000) per individual, or six thousand dollars ($6,000) per couple. The department shall provide medical assistance coverage to such elderly or disabled persons in the same amount, duration and scope as provided to other categorically needy persons under the state's Title XIX state plan.

~~(b) In order to ensure that individuals with disabilities have access to quality and affordable health care, the department is authorized to plan and to implement a system of health care delivery through voluntary (opt-out) managed care health systems for such individuals. "Managed care" is defined as systems that: integrate an efficient financing mechanism with quality service delivery; provides a "medical home" to assure appropriate care and deter unnecessary and inappropriate care; and places emphasis on preventive and primary care.~~

~~(c) The department is authorized to obtain any approval and/or waivers from the United States Department of Health and Human Services, necessary to implement a voluntary (opt-out) managed health care delivery system to the extent approved by the United States Department of Health and Human Services, including a primary care case management model in which ancillary services are provided under the direction of a physician in a practice that meets standards established by the department of human services. Nothing in this subsection shall be interpreted to reduce the scope or duration of services or benefits covered for any Medicaid recipient or to restrict or remove any services or benefits from a managed care benefit plan provided by the state Medicaid program.~~

~~(d) The department shall submit a report to the permanent joint committee on health care oversight no later than April 1, 2006 that proposes an implementation plan for this voluntary program, based on beginning enrollment not sooner than July 1, 2006. The report will describe projected program costs and savings, the outreach strategy to be employed to educate the potentially eligible populations, the enrollment plan, and an implementation schedule.~~

~~(e) To ensure the delivery of timely and appropriate services to persons who become automatically eligible for Medicaid by virtue of their eligibility for a Social Security Administration program, data on their special needs may be reported to the department of human services by the Social Security Administration. The department of human services is authorized to seek any and all data sharing agreements or other agreements with the Social Security Administration as may be necessary to receive timely and accurate~~

~~diagnostic data and clinical assessments to be used exclusively for the purpose of service planning, and to be held and exchanged in accordance with all applicable state and federal medical record confidentiality laws and regulations.~~

SECTION 15. Section 40-8.5- 1.1 of the General Laws in Chapter 40-8.5 entitled "Health Care for Elderly and Disabled Residents Act " is hereby added as follows:

40-8.5-1.1 Managed health care delivery systems. (a) To ensure that all medical assistance recipients, including the elderly, all individuals with disabilities, have access to quality and affordable health care, the department of human services is authorized to plan and to implement a system of health care delivery for all medical assistance recipients, through a mandatory managed care health systems for such individuals.

(b) "Managed care" is defined as systems that: integrate an efficient financing mechanism with quality service delivery; provides a "medical home" to assure appropriate care and deter unnecessary and inappropriate care; and places emphasis on preventive and primary care. For purposes of Medical Assistance, managed care is also defined as to include a primary care case management model in which ancillary services are provided under the direction of a physician in a practice that meets standards established by the department of human services. Those medical assistance recipients who have third party medical coverage or insurance may be exempt from mandatory managed care in accordance with rules and regulations promulgated by the department of human services through the rule making process. The department is further authorized to redesign benefit packages for medical assistance recipients subject to the appropriate federal approval of all necessary waivers and state plan amendments.

(c) The department is authorized to obtain any approval through waiver(s)s and/or state plan amendments from the secretary of the United States Department of Health and Human Services, necessary to implement a mandatory managed health care delivery system for all medical assistance recipients, including the primary case management model in which ancillary services are provided under the direction of a physician in a practice that meets standards established by the department of human services. The

waiver and/or state plan amendment authorization in this section includes the authorization that those medical assistance recipients who have third party medical coverage or insurance may be exempt from mandatory managed care in accordance with rules and regulations promulgated by the department of human services and further, that the department may redesign benefit packages for medical assistance recipients also in accordance with rules and regulations promulgated by the department.

(d)To ensure the delivery of timely and appropriate services to persons who become automatically eligible for Medicaid by virtue of their eligibility for a Social Security Administration program, data on their special needs may be reported to the department of human services by the Social Security Administration. The department of human services is authorized to seek any and all data sharing agreements or other agreements with the Social Security Administration as may be necessary to receive timely and accurate diagnostic data and clinical assessments to be used exclusively for the purpose of service planning, and to be held and exchanged in accordance with all applicable state and federal medical record confidentiality laws and regulations.

(e) The department of human services and/or the executive office of health and human services is authorized and directed to apply for and obtain any necessary waiver (s) and/or state plan amendments from the secretary of the United States Department of Health and Human Services, including, but not limited to, a waiver of the appropriate sections of law for the purpose of administering and implementing the goals of the Medicaid Reform 2009 as described in 42- 7.2-12 of the General Laws, specifically using competitive value based purchasing to maximize the available service options and to promote accountability and transparency in the delivery of services for all medical assistance recipients.

(f) Any approved medical assistance provider who declines to participate in contracting for benefits in any one of the department's medical assistance programs, including, but not limited to RIteCare, may be denied participation in all state operated medical assistance programs at the discretion of the department.

SECTION 16. Section 15 of this Article shall take effect upon passage. Any rules or regulations necessary or advisable to implement the provisions of Section 15 of this Article shall be effective immediately as an emergency rule upon the department's filing thereof with the secretary of state as it is hereby found that the current fiscal crisis in this state has caused an imminent peril to public health, safety and welfare, and the department is hereby exempted from the requirements of sections 42-35-3(b) and 42-35-4(b)(2) relating to agency findings of imminent peril to public health, safety and welfare and the filing of statements of the agency's reasons thereof.

RELATING TO DHS

SECTION 17. Section 40-18-3 of the General Laws in Chapter 40-18 entitled "Long Term Home Health Care – Alternative to Placement in a Skilled Nursing or Intermediate Care Facility " is hereby amended as follows:

§ 40-18-3 Patient assessment and provision of services. – (a) The services defined and delineated in § 40-18-2 shall be provided only to those hospitalized patients who are medically eligible for placement in a skilled nursing facility and/or intermediate care facility. Provision of long term home health care services paid for by government funds shall be based upon, but not limited to, a comprehensive assessment that shall include, but not be limited to, an evaluation of the medical, social, and environmental needs of each applicant for the services or program. This assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the applicant. In cases in which the applicant is a patient in a hospital, the assessment shall be completed by persons designated by the director, including, but not limited to, the applicant's physician, the discharge coordinator of the hospital, and a representative of the department of human services.

(b) Continued provision of long term home health care services paid for by government funds shall be based upon a comprehensive assessment of the medical, social, and environmental needs of the recipient of the services. ~~The assessment shall be performed at least every one hundred eighty (180) days by the department of human services.~~

RELATING TO THE DHS

SECTION 18 Section 40-21-1 of the General Laws in Chapter 40-21-1 entitled "Medical Assistance-Prescription Drugs" is hereby amended as follows:

§ 40-21-1 Prescription drug program. – The department of human services is hereby authorized and directed to amend its practices, procedures, regulations and the Rhode Island state plan for medical assistance (Medicaid) pursuant to title XIX of the Federal Social Security Act [42 U.S.C. § 1396 et seq.] to modify the prescription drug program:

(1) To establish a preferred drug list (PDL);

(2) To enter into supplemental rebate, discount or other agreements with pharmaceutical companies; and

(3) To negotiate either state-specific supplemental rebates or to participate in a multi-state pooling supplemental rebate program.

Determinations of drugs included on the PDL will be made by the State Department of Human Services, and a listing of such drugs shall be maintained on a public website. In making these determinations, the department shall consider the recommendations of the Medicaid Pharmaceutical and Therapeutics Committee, whose membership shall include practicing pharmacists and physicians, faculty members of the University of Rhode Island's College of Pharmacy, and consumers or consumer representatives. Drugs exempt from the PDL shall include: ~~(1) antipsychotics;~~ ~~(2)~~ (1) anti-retrovirals; and ~~(3)~~ (2) organ

transplant medications. Physicians will be informed about prior authorization procedures for medications not on the PDL, and seventy-two (72) hour emergency supplies may be dispensed if authorizations cannot be obtained.

SECTION 19. Section 18 of this Article shall take effect upon passage. Any rules or regulations necessary or advisable to implement the provisions of Section 18 of this Article shall be effective immediately as an emergency rule upon the department's filing thereof with the secretary of state as it is hereby found that the current fiscal crisis in this state has caused an imminent peril to public health, safety and welfare, and the department is hereby exempted from the requirements of sections 42-35-3(b) and 42-35-4(b)(2) relating to agency findings of imminent peril to public health, safety and welfare and the filing of statements of the agency's reasons thereof.

Relating to MHRH

SECTION 20. Section 40.1-21-4.4 of the General laws in Chapter 40.1-21 entitled " Division of Developmental Disabilities" is hereby repealed as follows:

~~**40.1-21-4.4 Medical assistance – Managed care system.** – (a) In order to ensure that adult persons who are developmentally disabled have access to an appropriate array and level of services, the department of mental health, retardation and hospitals, with the assistance of the department of human services, is authorized to plan and to implement a system of service delivery through a managed care system for developmentally disabled adults. "Managed care" is defined as a system that: consolidates all current state and federal funding streams for persons with developmental disabilities to maintain and expand the broad range of primary, preventive and continuing care community based service options under a single funding mechanism; integrates the single funding mechanism with quality service delivery; and provides a "managed care home" to assure appropriate services and deter unnecessary and inappropriate services.~~

~~(b) The department of human services, with the assistance of the department of mental health, retardation, and hospitals, is authorized to seek any approval and/or waivers from the U.S. Department of Health and Human Services, Health Care Financing Administration, necessary to implement a mandatory managed care system for persons with developmental disabilities who are eligible for medical assistance under Title XIX of the federal Social Security Act, 42 U.S.C. § 1396 et seq. Prior to submitting such request for approvals and/or waivers, the department shall submit them to the medical assistance advisory committee for comprehensive review and comment. Subsequent applications shall be submitted to the medical assistance advisory committee at least one month prior to submission. The medical assistance advisory committee, to the extent not prohibited by federal law or regulation, shall include legislative members. The department of mental health, retardation, and hospitals, with the assistance of the department of human services, shall identify the initial populations and geographical areas where managed care shall begin. The department of health, in cooperation with the departments of human services and mental health, retardation, and hospitals, shall annually develop and implement a survey and evaluation of all managed care programs to measure service outcomes and consumer satisfaction. These results shall be published and made available to the public.~~

RELATING TO EOHHS

SECTION 21. Sections 42-7.2-12 and Section 42-7.2-12.1 of the General Laws in Chapter 42-7.2 entitled " Office of Health and Human Services" is hereby repealed as follows:

~~**§ 42-7.2-12 Medicaid program study.** (a) The secretary of the executive office of health and human services shall conduct a study of the Medicaid programs administered by the state to review and analyze the options available for reducing or stabilizing the level of uninsured Rhode Islanders and containing Medicaid spending.~~

~~(1) As part of this process, the study shall consider the flexibility afforded the state under the federal Deficit Reduction Act of 2006 and any other changes in federal Medicaid policy or program requirements occurring on or before December 31, 2006, as well as the various approaches proposed and/or adopted by other states through federal waivers, state plan amendments, public-private partnerships, and other initiatives.~~

~~(2) In exploring these options, the study shall examine fully the overall administrative efficiency of each program for children and families, elders and adults with disabilities and any such factors that may affect access and/or cost including, but not limited to, coverage groups, benefits, delivery systems, and applicable cost-sharing requirements.~~

~~(b) The secretary shall ensure that the study focuses broadly on the Medicaid programs administered by all five (5) of the state's five (5) health and human services departments, irrespective of the source or manner in which funds are budgeted or allocated. The directors of the departments shall cooperate with the secretary in preparing this study and provide any information and/or resources the secretary deems necessary to assess fully the short and long-term implications of the options under review both for the state and the people and the communities the departments serve. The secretary shall submit a report and recommendations based on the findings of the study to the general assembly and the governor no later than March 1, 2007.~~

~~**§ 42-7.2-12.1 Human services call center study (211).**~~ ~~(a) The secretary of the executive office of health and human services shall conduct a feasibility and impact study of the potential to implement a statewide 211 human services call center and hotline. As part of the process, the study shall catalog existing human service information hotlines in Rhode Island, including, but not limited to, state-operated call centers and private and not-for-profit information hotlines within the state.~~

~~(1) The study shall include analysis of whether consolidation of some or all call centers into a centralized 211 human services information hotline would be economically and practically advantageous for both the public users and agencies that currently operate separate systems.~~

~~(2) The study shall include projected cost estimates for any recommended actions, including estimates of cost additions or savings to private service providers.~~

~~(b) The directors of all state departments and agencies shall cooperate with the secretary in preparing this study and provide any information and/or resources the secretary deems necessary to assess fully the short and long-term implications of the operations under review both for the state and the people and the communities the departments serve.~~

(c) The secretary shall submit a report and recommendations based on the findings of the study to the general assembly, the governor, and the house and senate fiscal advisors no later than February 1, 2007.

RELATING TO DHS

SECTION 22. Section 42-12.3-3 of the General Laws in Chapter 42-12.3 entitled "Health Care for Children and Pregnant Woman" is hereby amended to read as follows:

§ 42-12.3-3 Medical assistance expansion for pregnant women/RIte Start. – (a) The director of the department of human services is authorized to amend its title XIX state plan and/or waiver pursuant to title XIX of the Social Security Act to provide Medicaid coverage through expanded family income disregards for pregnant women whose family income levels are between one hundred eighty-five percent (185%) and two hundred fifty percent (250%) of the federal poverty level as authorized by the federal Secretary of Health and Human Services The department is further authorized to promulgate any regulations necessary and in accord with title XIX [42 U.S.C. § 1396 et seq.] of the Social Security Act to implement said state plan amendment and/or waiver. The services shall be in accord with title XIX [42 U.S.C. § 1396 et seq.] of the Social Security Act.

(b) The director of the department of human services is authorized and directed to establish a payor of last resort program to cover prenatal, delivery and postpartum care.

The program shall cover the cost of maternity care for any woman who lacks health insurance coverage for maternity care and who is not eligible for medical assistance under title XIX [42 U.S.C. § 1396 et seq.] of the Social Security Act including, but not limited to, a non-citizen pregnant woman lawfully admitted for permanent residence on or after August 22, 1996, without regard to the availability of federal financial participation, provided such pregnant woman satisfies all other eligibility requirements. The director shall promulgate regulations to implement this program. Such regulations shall include specific eligibility criteria; the scope of services to be covered; procedures for administration and service delivery; referrals for non-covered services; outreach; and public education. Excluded services under this paragraph will include, but not be limited to, induced abortion except to prevent the death of the mother.

(c) The department of human services may enter into cooperative agreements with the department of health and/or other state agencies to provide services to individuals eligible for services under subsections (a) and (b) above.

(d) The following services shall be provided through the program:

(1) Ante-partum and postpartum care;

(2) Delivery;

(3) Cesarean section;

(4) Newborn hospital care;

(5) Inpatient transportation from one hospital to another when authorized by a medical provider;

(6) Prescription medications and laboratory tests;

(e) The department of human services shall provide enhanced services, as appropriate, to pregnant women as defined in subsections (a) and (b), as well as to other pregnant women eligible for medical assistance. These services shall include: care coordination,

nutrition and social service counseling, high risk obstetrical care, childbirth and parenting preparation programs, smoking cessation programs, outpatient counseling for drug-alcohol use, interpreter services, mental health services, and home visitation. The provision of enhanced services is subject to available appropriations. In the event that appropriations are not adequate for the provision of these services, the department has the authority to limit the amount, scope and duration of these enhanced services.

(f) The department of human services shall provide for extended family planning services for up to twenty-four (24) months postpartum. These services shall be available to women who have been determined eligible for RIte Start or for medical assistance under title XIX [42 U.S.C. § 1396 et seq.] of the Social Security Act.

RELATING TO DEA

SECTION 23. Section 42-66-4 of the General Laws in Chapter 42-66 entitled "Elderly Affairs Department ." is hereby amended to read as follows:

§ 42-66-4 Duties of the department. [Effective January 1, 2008.]. – (a) The department shall be the principal agency of the state to mobilize the human, physical, and financial resources available to plan, develop, and implement innovative programs to insure the dignity and independence of elderly persons, including the planning, development, and implementation of a home and long-term care program for the elderly in the communities of the state.

(b) The department shall serve as an advocate for the needs of the adult with a disability as these needs and services overlap the needs and services of elderly persons.

(2) The department shall serve as the state's central agency for the administration and coordination of a long term care entry system, using community-based access points, that will provide the following services related to long term care: information and referral, initial screening for service and benefits eligibility, and a uniform assessment program for state supported long term care.

(3) The department shall investigate reports of elder abuse, ~~and~~ neglect, <u>exploitation, or self-neglect</u> and shall provide and/or coordinate protective services.

(c) To accomplish these objectives, the director is authorized:

(1) To provide assistance to communities in solving local problems with regard to elderly persons including, but not limited to, problems in identifying and coordinating local resources to serve the needs of elderly persons;

(2) To facilitate communications and the free flow of information between communities and the offices, agencies and employees of the state;

(3) To encourage and assist communities, agencies, and state departments to plan, develop, and implement home and long-term care programs;

(4) To provide and act as a clearinghouse for information, data, and other materials relative to elderly persons;

(5) To initiate and carry out studies and analyses which will aid in solving local, regional, and statewide problems concerning elderly persons;

(6) To coordinate those programs of other state agencies designed to assist in the solution of local, regional, and statewide problems concerning elderly persons;

(7) To advise and inform the governor on the affairs and problems of elderly persons in the state;

(8) To exercise the powers and discharge the duties assigned to the director in the fields of health care, nutrition, homemaker services, geriatric day care, economic opportunity, local and regional planning, transportation, and education and pre-retirement programs;

(9) To further the cooperation of local, state, federal and private agencies and institutions providing for services or having responsibility for elderly persons;

(10) To represent and act on behalf of the state in connection with federal grant programs applicable to programs for elderly persons in the functional areas described in this chapter;

(11) To seek, accept, and otherwise take advantage of all federal aid available to the department, and to assist other agencies of the state, local agencies, and community groups in taking advantage of all federal grants and subventions available for elderly persons and to accept other sources of funds with the approval of the director of administration which shall be deposited as general revenues;

(12) To render advice and assistance to communities and other groups in the preparation and submission of grant applications to state and federal agencies relative to programs for elderly persons;

(13) To review and coordinate those activities of agencies of the state and of any political subdivision of the state at the request of the subdivision, which affect the full and fair utilization of community resources for programs for elderly persons, and initiate programs that will help assure such utilization;

(14) To encourage the formation of councils on aging and to assist local communities in the development of the councils;

(15) To promote, and coordinate day care facilities for the frail elderly who are in need of supportive care and supervision during the daytime;

(16) To provide and coordinate the delivery of in-home services to the elderly, as defined under the rules and regulations ~~proposed by the in-home services commission and~~ adopted by the department of elderly affairs;

(17) To advise and inform the public of the risks of accidental hypothermia;

(18) To establish a clearinghouse for information and education of the elderly citizens of the state;

(19) To establish and operate in collaboration with community and aging service agencies a statewide family-caregiver resource network to provide and coordinate family-caregiver training and support services to include counseling and respite services;

(20) To provide and coordinate the "elderly/disabled transportation" program including a passenger cost sharing program as defined and provided for under rules and regulations adopted by the department in the rule making process; and

(21) To supervise the citizens' commission for the safety and care of the elderly created pursuant to the provisions of chapter 1.4 of title 12.

(d) In order to assist in the discharge of the duties of the department, the director may request from any agency of the state information pertinent to the affairs and problems of elderly persons.

SECTION 24. Section 23 of this Article shall take effect upon passage. Any rules or regulations necessary or advisable to implement the provisions of Section 23 of

this Article shall be effective immediately as an emergency rule upon the department's filing thereof with the secretary of state as it is hereby found that the current fiscal crisis in this state has caused an imminent peril to public health, safety and welfare, and the department is hereby exempted from the requirements of sections 42-35-3(b) and 42-35-4(b)(2) relating to agency findings of imminent peril to public health, safety and welfare and the filing of statements of the agency's reasons thereof.

RELATING TO DEA

SECTION 25. Section 42-66.3-1 of the General Laws in Chapter 42-66.3 entitled " Home and Community Services to the Elderly"" is hereby amended to read as follows:

§ 42-66.3-1 Definitions. – As used in this chapter:

(1) "Adult day services program" is an agency licensed through the department of ~~elderly affairs~~ health that provides a comprehensive supervised program on a regular basis to physically and/or mentally handicapped adults for a substantial part of a day in a single physical location for a specified number of participants daily. Adult day services may include, medical supervision, social and educational activities, snacks and/or hot lunch.

(2) "Case management agency" means a community-based agency designated by the department of elderly affairs to provide ~~case management service~~ care coordination for home and community care clients.

(3) "Director" means the director of the department of elderly affairs.

(4) "Home and community care services" means arranging for or providing directly to the client or providing through contract ~~arrangement adult day~~ services – such as home health aid/homemaker services and such other services that may required for a client to remain in the community and as defined by department regulation through the rulemaking process.

(5) "Home care agency" means an agency licensed by the department of health as a "home nursing provider" and/or "home care provider" under the provisions of chapter 17 of title 23.

(6) "Long-term care ombudsperson" means the person or persons designated by the director of the department of elderly affairs for the purpose of advocating on behalf of recipients of long-term care services and of receiving, investigating and resolving through mediation, negotiation and administrative action complaints filed by recipients of long-term care services; individuals acting on their behalf or any individual organization or government agency that has reason to believe that a long-term care agency has engaged in activities, practices or omissions that constitute a violation of applicable statutes or regulations or that may have an adverse effect upon the health, safety, welfare, rights or the quality of life of recipients of long-term care services.

(7) "Home health aide services" means simple health care tasks, personal hygiene services, housekeeping tasks essential to the patient's health, and other related supportive services. These services shall be in accordance with a plan of treatment for the patient and shall be under the supervision of the appropriate health care professional. These services shall be provided by a person who meets the standards established by the department of health.

(8) "Homebound" means the condition of the client is such that the client does not have the normal ability to leave home, consequently leaving the home requires a considerable and taxing effort by the client. A client does not have to be confined to bed to be homebound.

(9) "Homemaker services" means assistance and instruction in managing and maintaining a household and incidental household tasks for persons at home because of illness, incapacity, or the absence of a caretaker relative. These services shall be provided by a person who meets the standards established by the department of health.

(10) "Assisted living residences" means a publicly or privately operated residence that is ~~provides directly or indirectly by means of contracts or arrangements personal assistance to meet the resident's changing needs and preferences, lodging, and meals to two (2) or more adults who are unrelated to the licensee or administrator, excluding however, any privately operated establishment or facility~~ licensed pursuant to 23-17-4 of

the General Laws as amended. ~~17 of title 23, as amended, and those facilities licensed by or under the jurisdiction of the department of mental health, retardation, and hospitals, the department of children, youth and families, or any other state agency. Assisted living residences include sheltered care homes, and board and care residences or any other entity by any other name providing the above services which meet the definition of assisted living facilities.~~

(11) "Respite care services" means temporary care given inside or outside the home of a client who cannot entirely care for themselves and thereby offers relief to caregivers. ~~For the purposes of this chapter, these services are provided by an agency funded by the department of elderly affairs to provide respite care services.~~

(12) "Shared living" program" means a privately owned residence in which the family provides for or arranges for the needs of the client so that the client can remain in the community, a program that is designed to respect the unique character of each individual, promotes self-reliance and the freedom to make choices, and fosters dignity, autonomy and personal safety. Services may be provided in-home or host home residence in which the family provides for or arranges for the needs of the client so that the client can remain in the community including but not limited to lodging and meals. This program is designed to provide the opportunity for the provision of an inter generational multidisciplinary supports to preserve and strengthen families.

RELATING TO DEA

SECTION 26 Section 42-66.3-3 of the General Laws in Chapter 42-66.3 entitled " Home and Community Services to the Elderly"" is hereby amended to read as follows:

42-66.3-3 Services available. – Home and community care services shall consist of:

(1) Medicaid waiver services for Medicaid eligible clients; or

(2) For the state funded co-payment program, ~~case management~~ care coordination, a combination of homemaker/personal care services and other support services deemed necessary by the director.

SECTION 27. Section 42-66.3-3 of the General Laws in Chapter 42-66.3 entitled " Home and Community Services to the Elderly"" is hereby amended to read as follows:

42-66.3-4 Persons eligible. – (a) To be eligible for this program the client must be determined, through a functional assessment, to be in need of assistance with activities of daily living or ~~meets an institutional level of care;~~ and/or must meet a required level of care as defined in department rules and regulations adopted through the rulemaking process ;

(b) Medicaid eligible individuals age sixty-five (65) or older of the state who meet the financial guidelines of the Rhode Island medical assistance program ~~except that they may retain cash and/or liquid resources not exceeding four thousand dollars ($4,000) for an individual and six thousand dollars ($6,000) for a married couple,~~ as defined in department rules and regulations adopted through the rule making process shall be provided the services without charge; or

(c) Persons eligible for assistance under the provisions of this section, subject to the annual appropriations deemed necessary by the general assembly to carry out the provisions of this chapter, include: (1) any homebound unmarried resident or homebound married resident of the state living separate and apart, who is at least sixty-five (65) years of age, ineligible for Medicaid, and whose income does not exceed the income eligibility ~~for persons eligible under § 42-66.2-5(a)(1)(i) and (a)(2)(i) for the Rhode Island pharmaceutical assistance to the elderly program;~~ limits as defined by the department in rules and regulations adopted through the rule making process and (2) any married resident of the state who is at least sixty-five (65) years of age, ineligible for Medicaid, and whose income when combined with any income of that person's spouse does not exceed the income eligibility ~~for persons eligible under § 42-66.2-5(a)(1)(i) and (a)(2)(i) for the Rhode Island pharmaceutical assistance to the elderly program.~~ limits as defined

in department rules and regulations adopted through the rule making process. Persons who meet the eligibility requirement of this subsection shall be eligible for the co-payment portion as set forth in § 42-66.3-5.

SECTION 28. Section 27 of this Article shall take effect upon passage. Any rules or regulations necessary or advisable to implement the provisions of Section 27 of this Article shall be effective immediately as an emergency rule upon the department's filing thereof with the secretary of state as it is hereby found that the current fiscal crisis in this state has caused an imminent peril to public health, safety and welfare, and the department is hereby exempted from the requirements of sections 42-35-3(b) and 42-35-4(b)(2) relating to agency findings of imminent peril to public health, safety and welfare and the filing of statements of the agency's reasons thereof.

SECTION 29. Chapter 66.8 in Title 42 of the General Laws entitled "Rhode Island Assisted Housing Living Waiver" is hereby amended as follows:

42-66.8-1. Legislative findings. – It is found and declared as follows:

(1) Rhode Island has one of the highest proportions of elderly persons in the nation. Persons age eighty-five (85) years old and over are the fastest growing segment of the state's population.

(2) A significant number of Rhode Island elderly have difficulty carrying out basic life activities, and many are at high risk for institutionalization due to chronic illness and disability.

(3) There is a growing consumer preference for more housing and care alternatives designed specifically for persons who need assistance with basic life activities, but do not need the level of skilled nursing care and therapy that nursing homes provide.

(4) There exists a lack of private sector initiatives to create assisted living options which are affordable to low and moderate income frail elderly and other frail persons.

(5) It is imperative for state government and long-term health providers to develop cost effective means of caring for at-risk elderly, and in particular those low and moderate

income frail elderly whose needs are appropriate for assisted living placement but who cannot afford the costs of market rate, private pay assisted living facilities.

(6) An alternative form of housing and care must be developed in Rhode Island for low and moderate income frail elderly and other frail persons to enable them to live in a residential setting as independently as possible while achieving cost savings in the state Medicaid program.

(7) An assisted living demonstration program, sponsored by the state through the collaboration and cooperation of the Rhode Island housing and mortgage finance corporation, the department of elderly affairs, and the department of human services, will allow the state to provide appropriate housing and care needed by frail elderly and other frail persons in Rhode Island and to evaluate the cost savings and other benefits of assisted living.

§ 42-66.8-2 Purpose – Assisted living waiver request. – The purpose of this legislation is to provide assisted living alternatives to low and moderate income chronically impaired or disabled elderly and other chronically impaired or disabled adults who are eligible for or at risk of placement in nursing facility care. The director of the department of elderly affairs and the director of the department of human services shall cooperate and collaborate in obtaining approval from the health care financing administration for a home and community based services waiver designated to fund assisted living supportive services for up to two hundred (200) persons residing in assisted living facilities certified and financed by the Rhode Island housing and mortgage finance corporation. The director of the department of elderly affairs and the director of the department of human services shall formulate the waiver application and submit the waiver request no later than September 30, 1997. The waiver shall be reviewed and expanded periodically as funding is made available.

§ 42-66.8-3 Definitions. – As used in this chapter, unless the context otherwise requires:

(1) An "assisted living facility" means a publicly or privately operated residential development (including a designated wing or section of that development) certified and

financed by the Rhode Island housing and mortgage finance corporation that provides lodging, meals and assisted living supportive services to two (2) or more adults and which is licensed by the state pursuant to chapter 17.4 of title 23; excluding, however, those facilities licensed by or under the jurisdiction of the department of mental health, retardation and hospitals, the department of children, youth and families, or any other state agency.

(2) "Assisted living rules and regulations and guidelines" means the rules and regulations of the Rhode Island housing and mortgage finance corporation applicable to the rental housing production and rehabilitation program, as those rules and regulations may be amended from time to time, and the resources and guidelines for assisted living developments adopted by the board of commissioners of the Rhode Island housing and mortgage finance corporation, as those guidelines may be amended from time to time.

(3) "Assisted living supportive services" means: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under state law), therapeutic social and recreational programming, provided in a home-like environment in a licensed assisted living facility, in conjunction with residing in the facility. This service includes twenty-four (24) hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the assisted living facility, but the care provided by these other entities supplements that provided by the assisted living facility and does not supplant it.

"Assisted living services" will also include transportation specified in the plan of care.

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living supportive services. Payment will not be made for twenty-four (24) hour skilled care or supervision.

(4) An "assisted living unit" means an apartment, condominium, bed or other dwelling quarters in an assisted living facility as defined by this chapter.

(5) "Certified" means the assisted living facility has been determined by Rhode Island housing to comply with its rules, regulations and guidelines for assisted living.

(6) "Government funds" means funds provided under the provisions of chapter 8 of title 40.

(7) "Long-term care assessment" means a program, approved by the directors of human services and elderly affairs, that provides a uniform health, social and functional assessment of persons in need of long-term care services due to chronic impairment or disability.

(8) "Rhode Island housing" means that public corporation authorized and created by § 42-55-4.

§ 42-66.8-4 Provision of service. – (a) Provision of assisted living supportive services paid for with government funds in an assisted living facility as defined and delineated in this chapter shall be provided only to those persons who are eligible for, or at risk for, placement in a nursing facility and who have had a long-term care assessment which indicates the person can receive appropriate care in the assisted living facility.

(b) The long-term care assessment required under this chapter shall be completed by persons designated by the director of elderly affairs and the director of the department of human services and shall include representatives of the department of human services and persons designated by the department of elderly affairs to provide long-term care assessment services under § 42-66.6-3.

(c) If a person determined to be eligible to receive waiver services under this chapter desires to reside in an assisted living unit and an appropriate assisted living facility is available, the department of elderly affairs shall authorize the placement.

(d) Continued provision of assisted living supportive services paid for with government funds in an assisted living facility shall be based on a reassessment of the recipient's care needs to be performed at least every one hundred and eighty (180) days.

§ 42-66.8-5 Duties of director of human services. – For the purposes of this section, director means the director of human services. Notwithstanding any inconsistent provision of law, but subject to the expenditure limitations of this chapter, the director, subject to the approval of the state director of the budget, may authorize the utilization of medical assistance funds to pay for assisted living supportive services provided by

specified assisted living facilities in addition to those services included in the medical assistance program under title 40 of this code, so long as federal financial participation is available for those services. Expenditures made under this subdivision shall be deemed payments for medical assistance for needy persons.

(1) The department shall not make payments pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. § 1396 et seq., for benefits available under Title XVIII of that act, 42 U.S.C. § 1395 et seq., without documentation that Title XVIII claims have been filed and denied.

(2) The department shall not make payments for a person receiving assisted living services while payments are being made for that person under another Medicaid waiver program or for inpatient care in a skilled nursing and intermediate care facility or hospital; provided, however, this shall not effect monthly payments made under prospective reimbursement contracts.

§ 42-66.8-6 Evaluation of assisted living waiver demonstration. – Upon implementation of the demonstration program and occupancy of assisted living facilities by low and moderate income persons, the Rhode Island department of elderly affairs will work in conjunction with Rhode Island housing to develop a tool to evaluate the qualitative benefits and cost effectiveness of the demonstration program.

§ 42-66.8-7 Additional assisted living waiver request. – In addition to the waiver request required by § 42-66.8-2, the directors of the departments of human services and elderly affairs shall cooperate and collaborate in obtaining approval from the health care financing administration for additional home and community based waiver services designated to fund assisted living support services for an additional one hundred eighty (180) persons, including fifty (50) persons with Alzheimer's disease or another dementia with similar care and service needs, residing in licensed assisted living residences that demonstrate the capacity to meet the standards for service and care required under the conditions of the waiver. Application for the additional one hundred eighty (180) persons shall be submitted to the federal government by January 1, 2002. For purposes of this section, "assisted living residence" means those facilities licensed by the state pursuant to chapter 17.4 of title 23.

42-66.8-8 (a) The executive office of health and human services and/or the department of human services are authorized and shall apply for and obtain any necessary waivers and/or state plan amendments from the secretary of the United States Department of Health and Human Services, including, but not limited to, a waiver of the appropriate sections of Title XIX, 42 U.S.C. § 1396 et seq. The waiver shall be designed to bring medical assistance recipients who have been admitted to nursing homes back into the community and to help more medical assistance recipients remain in the community, as they require long-term care, thereby resulting in improved health, quality of life and more cost effective care.

(b) The provisions of sections 42-66.8- 1 through 42-66.7 shall be repealed effective upon the approval of the necessary waivers and/or state plan amendments from the secretary of the United States Department of Health and Human Services, including, but not limited to, a waiver of the appropriate sections of Title XIX, 42 U.S.C. § 1396 et seq. obtained in accordance with 42-66.8-8(a) above.

(c)The executive office of the health and human services and the human service agencies as defined in 42-7.2-2 are authorized and directed to adopt rules and regulations to ensure the establishment and implementation of this section in accordance with the intent and purpose outlined in this section, the requirements of Title XIX and any approved federal waivers and/or state plan amendments and further, to adequately notify the public that the necessary approvals of this section have been met, and that the provisions of sections 42-66.8- 1 through 42-66.7 shall be repealed in accordance with section 42-66.8-8 (b) above.

SECTION 30. Unless otherwise specified, all Sections of the Article shall take effect upon passage.